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Supportive Psychotherapy with the Dual Diagnosis Patient: Co-occurring Mental Illness/Intellectual Disabilities

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ABSTRACT

Psychiatrists and other mental health professionals can offer much in the care of patients with intellectual disabilities, including state-of-the-art medication regimens, psychotherapy, and other behavior therapies. Individuals with intellectual disabilities experience the full range of mental illnesses, but are often thought to be incapable of participating in or responding to psychotherapy. The following composite cases illustrate some of the psychotherapy techniques employed in a community psychiatry setting that serves patients with intellectual disabilities and co-occurring mental illness.

INTRODUCTION

Individuals with intellectual disabilities (ID) and/or other developmental disabilities experience the full range of psychiatric disorders at rates higher than the general population.[1,2] Many psychiatric disorders are misdiagnosed, under-diagnosed, or undiagnosed in this population. From the limited data available, it appears that depressive

EDITOR NOTE: All cases presented in the series "Psychotherapy Rounds" are composites constructed to illustrate teaching and learning points, and are not meant to represent actual persons in treatment.

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disorders and anxiety disorders are under-diagnosed and psychotic disorders are over-diagnosed.[1,2] Along the same lines, antidepressants and anxiolytics are under-prescribed and antipsychotics are typically over-prescribed. The co-occurrence of intellectual disability and mental illness has been referred to as *dual diagnosis*. It is estimated that as many as 30 to 40 percent of persons with ID are dually diagnosed.[2] When a person with ID needs mental health services, it is difficult to find professionals who are trained in both intellectual disabilities and mental illness. Professionals, who are trained in either mental health or ID, but not both, are often reluctant to serve individuals with dual diagnosis. There are separate service systems for mental health and ID, which contributes to the problem. People with dual diagnosis are said to fall through the cracks between the two service systems, at times resulting in neither mental health nor ID willing to claim ownership. This is a problem nationwide.

Historically, healthcare professionals have believed that persons with ID enjoyed immunity from emotional stress and psychiatric disorders.[3] Maladaptive behaviors were perceived as a manifestation of the condition of intellectual disability, and not as a possible manifestation of a psychiatric disorder. A person with a mild intellectual disability was characterized as worry-free and, therefore, mentally healthy. A person who had severe intellectual disability could not verbally express his or her feelings and was then thought as being exempt from emotional stress.[3]

Sternlicht writes in his article about the crucial error that has been made when one believes that psychotherapy demands (at least) normal intelligence.[3] Sternlicht thinks that different therapeutic techniques may be used that are not limited by verbal abilities, such as ego-supportive therapy and relationship therapy. Sinason is of the opinion that psychotherapy treatment is possible even if the intelligence is limited.[3] All behavior has a meaning, and it is the therapeutic work to understand and translate this—to try to help the person with an intellectual disability recover the meaning of his or her life. The psychotherapy can serve to interpret behavior by listening and putting words to what is said non-verbally.[3]

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According to Sinason, psychotherapy can influence the emotional understanding but not the general intelligence.[3] Psychotherapy might give the person the ability to function better, both cognitively and emotionally. To get in touch with feelings previously avoided can help to make a human being "whole" and help to prevent functioning from a false self or a handicapped personality. Development and demonstration of empathy work in parallel—when a person gets in touch with someone else's sadness and sorrow, then he or she becomes aware of such feelings inside himself or herself.[3] Disturbances in thinking might aggravate the emotional object constancy and the development of mutuality in relations with others. The more severe the disability, the greater the need to work with and understand countertransference and the means of communication that the person with ID uses with the therapist.[3]

The aim of psychotherapy is to increase the ability to acknowledge, put up with, and express one's feelings, and thereby support the inner healing forces.[3] Because of the limited symbolic capacity that is associated with intellectual disabilities, often persons with dual diagnosis lack the internal psychic organization and linguistic skills necessary to process and express their internal experiences.[4] Often when these individuals come to therapy their inner world is in a state of chaos, and they need assistance with learning to identify, label, and express their thoughts and feelings. Psychotherapeutic treatment can help the client to reach connection and meaningfulness. Different ego abilities may be strengthened so that the person might develop increased independence, which is especially applicable to the patient with ID.[3]

Families struggle to care for individuals with dual diagnosis.[2] Many report that they are denied services or given the runaround when trying to locate the assistance their family member needs. People with dual diagnosis often live in more restrictive residential settings and have fewer educational and vocational opportunities than persons with ID alone. They may experience repeated or lengthy psychiatric hospitalizations, become homeless, and are vulnerable to victimization or placement in the correctional system. People with dual diagnosis need access to services, professionals need training, and service systems need to work collaboratively if the needs of this under-served population are to be met.

Clinicians need to be cognizant of the fact that individuals with disabilities enter into the process of psychotherapy with several disadvantages that can affect the outcome of treatment if not appropriately recognized and

addressed.[5,6] Keller points out that the majority of patients who present for psychotherapy self-refer; however, this is usually not the case for individuals with ID. Individuals with ID are often referred by concerned others due to disruptive behaviors that are interfering with their ability to function in the community.[7] The individuals being referred usually do not have any input into the choice of therapist, the time, frequency, and location of the appointments, and sometimes not even who is present during psychotherapy appointments. The referring provider often assumes that the focus of therapy will be the elimination of maladaptive behavior, although this implied goal may or may not be an issue of concern for the patient. There may be a tremendous amount of apprehension regarding the referral itself, as the patient may view the referral for services as a punishment or a consequence of inappropriate behaviors versus an opportunity for self-growth, discovery, and positive change.[7] Because of these facts, it is important to provide emotional support and spend time preparing the patient for the process of psychotherapy. This should include education regarding the purpose of psychotherapy (a safe place to freely talk about and learn to solve problems), what happens in psychotherapy, and clear expectations regarding each participant's role in the process.[7]

There is no universal classification system or definition of mental retardation. The *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* defines mental retardation utilizing three criterion: 1) intelligence quotient (IQ) score less than 70; 2) decrease in adaptive functioning in at least two areas; and 3) onset before age 18 years.[8] There is further breakdown of the four subsets by IQ (see Table 1 for details). Of the four types defined, about 85 percent fall into the category of mild mental retardation.[8] Approximately one percent of the population meets these criteria, and as many as three percent of the population have IQ below 70 but may not necessarily meet the additional criteria. The gender ratio is approximately three males to one female.

TABLE 1. Diagnostic criteria for mental retardation

A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test.	
B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, work, leisure, health, and safety.	
C. The onset before age 18 years.	
317 Mild mental retardation	IQ level 50–55 to approximately 70
318.0 Moderate mental retardation	IQ level 35–40 to 50-55
318.1 Severe mental retardation	IQ level 20–25 to 35-40
318.2 Profound mental retardation	IQ level below 20–25
319 Mental retardation, severity unspecified: When there is strong presumption of mental retardation but the person's intelligence is untestable by standard tests.	

Adapted from: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, DC, American Psychiatric Press Inc., 2000.

PSYCHOTHERAPY CASES OF PATIENTS WITH INTELLECTUAL DISABILITIES

The majority of patients with ID and co-occurring mental illness are referred to the mental health system with the chief complaint being verbal aggression, physical aggression, or property destruction.[2] The following two clinical vignettes illustrate the psychotherapy of two patients with intellectual disabilities.

Vanessa. Vanessa, a 33-year-old woman with mild ID, was referred for psychotherapy by her multidisciplinary team. She had a mental health history significant for multiple hospitalizations over the last several years at area hospitals for major depressive disorder, recurrent, moderate without psychosis. She was last discharged four months prior to this referral for psychotherapy.

Vanessa was born to an intact nuclear family with supportive parents and an older sister. Her sister had no mental health problems and no cognitive deficits. Vanessa began experiencing symptoms of depression during the years when her sister graduated from college, got married, and had two children. It became evident to Vanessa during these years that she would not attain the same status and accomplishments in society. Vanessa's medical history was significant for a seizure disorder, well controlled with an anticonvulsant (lamotrigine), which also may have added mood stabilization effects, and she also took sertraline for treatment of her depressive symptoms. She had functioned fairly well over the last several months, attending workshop five days weekly and living in a group home with two female roommates. Her sister and parents remain actively involved in her life.

During a recent medical appointment with her primary care doctor, it was recommended that she discontinue caffeine intake because

TABLE 2. Desirable elements of a supportive relationship

The setting allows for the following:
• A moderate to high level of activity in both participants
• Therapeutic structure
• Two-way communication
• Adjunctive use of medication
• Adjunction use of other treatments and therapies
The therapist shows the following:
• An involved, active attitude
• Willingness to develop and contribute to a real relationship
• An attempt to develop a positive transference

of its effect on her seizure disorder as well as recent onset initial insomnia and nocturnal enuresis. Vanessa's team reported that a focus on the elimination of caffeine resulted in behavioral outbursts and violence, and they requested that the focus of the treatment be to decrease aggression and increase willingness to adhere to the staff's requests. The psychotherapist's need to develop a therapeutic alliance with Vanessa and focus on her wants and needs was first priority.

Initially, the therapist felt the urgency of the situation especially secondary to the violence involved, but avoided the temptation to focus on the caffeine restriction. The therapist knew that her primary focus should be to ensure that Vanessa's needs for support and validation were met. Vanessa was angry and frustrated because of all of the controls and restrictions in her life, and expressed this through behavioral outbursts and aggression at the staff and others around her. Vanessa resented the staff for making decisions for her, and she was never informed by the primary care physician about the reason for the caffeine restriction. The first order of business in the psychotherapy is to build rapport and trust, and this is what the therapist focused on before addressing Vanessa's inappropriate behavior.

PRACTICE POINT: THE SUPPORTIVE RELATIONSHIP

The relationship between therapist and patient is often said to have three related but nevertheless distinguishable aspects: the real relationship, the working (or therapeutic) alliance, and the transferential relationship.[9] In supportive psychotherapy, the real relationship is typically the major source of support, and it provides the underpinnings for the development of the other two aspects.

It is important to define *support* so as to avoid misconceptions. A supportive relationship is not a friendship but may involve elements found in a friendship.[9] One approach is Jerome Frank's paradigm of psychotherapy, consisting of four "common features" of all therapies: 1) a structured, "trusting, confiding, emotional" relationship that boosts the patient's morale; 2) a treatment setting with an aura of safety and sanctuary; 3) a conceptual scheme or explanatory model for the patient's problems that provides a rationale for the patient's treatment and relief; and 4) therapeutic procedures consistent with the conceptual scheme that relieve the patient's anxiety and encourage new behaviors. Using Frank's paradigm, one can say that a nonspecific supportive relationship makes possible some quite specific strategies of change: reality testing and the learning of new coping behaviors, cognitive and experiential learning, and enhancement of self-esteem through mastery, competence, success in the setting of therapy, and actual success.[9] Table 2 examines the desirable elements of a supportive relationship. Especially important with regard to the patient with cognitive deficits is the non-judgment acceptance of patient's current state. The therapist must remember his or her role is not to make sure the patient does not consume caffeine, for example, nor is it the therapist's responsibility to ensure that the patient is no longer aggressive, although this may be a reflex reaction. Also pertinent to the therapists' work with the patient with ID is non-condemning, non-moralizing responses of the patient's failure. The therapist need not judge the patient for consuming caffeine, as in the case of Vanessa, nor for exhibiting behavioral problems in response to staff's control over the caffeine intake. In Vanessa's case, the elimination of caffeine was the responsibility of the staff to oversee. The responsibility of the therapist was to work with Vanessa on the broader issues of lack of control and anger over the restriction. Going for the affect will produce better results, and prevent the therapist from being added to the long list of people trying to enforce the new rule. Also important for the patient with ID is maximum allowance of patient's autonomy to make treatment and life decisions. In Vanessa's case, it would have been helpful for her to initially receive more detailed information about the reason for the caffeine restriction or to review some other possibilities or compromises.

In Vanessa's case, the elimination of caffeine was the responsibility of the staff to oversee. The responsibility of the therapist was to work with Vanessa on the broader issues of lack of control and anger over the restriction.

Table 3 includes the elements of a supportive relationship that must be carefully controlled if present.[9] Some of these are especially important in a

therapist-patient relationship if the patient has cognitive deficits or ID. For example, promotion of the patient's dependency (only as much as necessary to achieve goals of therapy and within ethical guidelines) is applicable since the patient with ID inherently has issues of dependency. The patient with ID has a lifelong need for assistance with finances, obtaining education and/or employment, housing, and supervision. These issues of dependency on others must be carefully managed by the therapist and must always follow ethical guidelines.

Table 4 outlines non-supportive elements in a relationship.[9] Recognizing undue influence from others on the patient's life is especially pertinent to the therapist working with patients with ID. One of the persistent issues with this patient population is the control others have over many aspects of their lives. It is vital that the therapist does not pity the patient but is able to show empathy. Since the therapist may be viewed by the patient as yet another authority figure, when making interventions, the therapist must be cautious not to talk down to the patient.

PSYCHOTHERAPY CASES OF PATIENTS WITH INTELLECTUAL DISABILITIES, CONTINUED

Rachel. Rachel was a 41-year-old single woman with mild ID and multiple medical conditions, including a disabling autoimmune disorder (systemic lupus erythematosus), which recently had been the cause of chronic pain, limitation of movement, and decrease in Rachel's ability for self-care. At her most recent medical appointment, she was told the condition was terminal and her pain and decreased mobility would worsen over time.

Rachel was born to a woman who abused alcohol during the pregnancy. She was born prematurely at 32 weeks gestation and was placed in foster care. She was eventually adopted by an older couple, with whom she lived until graduation from high school; at that time, she moved to a group home and lived there with one roommate. She had some difficult losses, including the death of her adoptive mother just two years previously. At that time, she participated in a grief/loss group offered by her mental health clinic, which she claimed was helpful. She continued to see her adoptive father very infrequently because he had multiple medical problems and was living in a nursing home.

Rachel's physical deterioration progressed at such a rapid rate that she experienced depressed mood, irritability, initial and middle insomnia, decreased concentration, and anger outbursts. She required assistance from the staff with the most basic things. She was confined to a wheelchair and could no longer attend workshop because of the chronic pain combined with decreased mobility. She was referred for psychotherapy by staff after becoming verbally and physically aggressive with multiple providers after receiving the news of her terminal condition. The psychotherapy took place at the group home where the patient lived because of transportation and mobility problems. The staff ensured her and the therapist that there was a confidential area in the home for the two to meet.

During the initial appointments, Rachel was very resistant to treatment. She always left the television on during sessions; her perception was that the therapist was there to "force" her to "behave." The therapist worked to provide education regarding the purpose of therapy; she also attempted to normalize and validate feelings of Rachel without judgment, and to avoid power struggles. The therapist allowed Rachel to leave the television on during the initial appointments, and during the fifth meeting, Rachel asked the staff to turn the television off in preparation for the therapist's arrival.

The therapist focused on establishing rapport and was able to begin to effectively address anger management and grief issues.

TABLE 3. Elements of a supportive therapeutic relationship that must be carefully controlled if present

Friendship
Uncritical agreement with the patient's view of himself or herself
Acceptance of delusional material
Acceptance of the patient's rationalizations for behavior and other defenses
Socialized and shared activities (meals, games, walks—depending on the patient's level of function)
Therapist's relationship with the patient's family
Therapist's judicious self-disclosure
Direct gratification, such as verbal praise, gifts, or food
Sympathy
Humor
Casual physical contact

PRACTICE POINT: GRIEF COUNSELING FOR ADULTS WITH INTELLECTUAL DISABILITIES

Adults with intellectual disabilities may be particularly vulnerable to maladaptive grief reactions for several reasons. Many have long histories of living in institutional settings or residential schools, which have exposed them to traumatic losses.[10,11] Being placed outside their family homes may lead them to feel the loss of a family unit, separation from early caretakers, and the loss of some personal freedoms. They often continue to suffer multiple losses as

TABLE 4. Non-supportive elements in a therapeutic relationship

Inactive therapist
Unstructured relationship
Undue influence on the patient's life
Romantic or sexual involvement
Pity
True peer relationship
Humoring the patient or the patient's family
Talking down to the patient
Tacit collusion or mutual avoidance of areas that need to be explored
Receiving or giving gratifications that do not serve a therapeutic purpose

staff members frequently turn over.[11]

The unsuccessful resolution of past losses may interfere with a person's ability to move forward in forming new relationships. Individuals with ID need help and guidance through the grieving process when a loved one dies.[11] Cognitive limitations may interfere with their ability to effectively express feelings or to grasp the abstract concepts related to death. Baseline levels of maladaptive behavior may increase in frequency during these times.

The therapist should pointedly spend time during the psychotherapy exploring previous losses and anticipate their resurfacing during the work in the room. In the case of Rachel, the patient faced her own mortality, so it was important to review what this means to her, discuss her wishes as she becomes more ill and less ambulatory, and address any "unfinished business" before she dies. Funeral arrangements should also be discussed, and if applicable, the therapist can facilitate communication of this information to appropriate staff or family.

PSYCHOTHERAPY CASES, CONTINUED

Vanessa. Vanessa began lying about sneaking caffeine and felt the therapist would "tell" on her. She had the perception that the therapist was working for the mental health clinic versus being there to support her. The therapist spent time providing education regarding everyone's roles and the boundaries in their relationship (confidentiality, etc). This quickly resulted in increased honesty and sharing of inner thoughts and feelings and relating intentions (to continue stealing). This allowed the therapist to address the issue, as opposed to the patient sitting in session and denying there was a problem.

Vanessa also exhibited explosive behavior outbursts, and early in the psychotherapy there was a need for follow up within a day or two of the incident to effectively process it and work on appropriate therapeutic issues. If the therapist had waited longer, Vanessa may not have adequately remembered the triggers for her actions, and her ability to effectively deal with the incident would have been lost. The therapist also needed to follow up with Vanessa's caregivers quickly to ensure they felt supported and had the necessary information regarding appropriate techniques to use should the behavior reoccur.

Rachel. Rachel was afraid to discuss issues related to her dissatisfaction with residential staff, and was especially worried about potential retribution. The therapist worked to establish a solid relationship and ensure her understanding of confidentiality and the privacy and safety within the psychotherapy relationship. Rachel was then able to share and process painful feelings related to her perception of how she was treated by staff.

Rachel began stealing and lying about her recent behaviors because she was afraid of rejection of the therapist. The group home staff communicated what transpired to the therapist so the incident could be addressed effectively in session. By building a rapport with Rachel, the therapist was able to provide a therapeutic intervention with regard to the ability to be honest in sessions. The therapist also utilized coping skill cards in sessions and recommended that staff refer Rachel to use these between sessions, which helped to reinforce the work in the room and served as a bridge between sessions and day-to-day living. This led to a dramatic increase in Rachel's ability to openly share her life experiences, wants, and needs, which subsequently led to a decrease and virtual elimination of anger outbursts and violence.

PRACTICE POINT: THE THERAPIST PROTECTS THE BOUNDARIES AND CONFIDENTIALITY OF THE PATIENT

Individuals with disabilities are embedded in multiple service delivery systems and often do not understand the purpose of therapy or how the therapeutic relationship/alliance is any different from their relationships with the multitude of other 'helpers' in their environment. It is the norm for these individuals to witness the free sharing of their personal information between other professionals involved in their care.[7] For this reason, in order to successfully build rapport and create a therapeutic alliance, it is essential to provide education regarding the boundaries inherent within the therapeutic relationship, which protects their confidentiality and ensures their privacy.

It is equally important and challenging for the therapist working with a patient with ID to protect the patient's confidentiality. As illustrated in the cases of Vanessa and Rachel, there will be information that the therapist needs to share with family members or staff who work directly with the patient.

However, this must be discussed with the patient before disclosure. The patient should receive a detailed explanation about confidentiality and the boundaries of same.

The therapy will not be effective if the patient's perception is that everything shared in the room is repeated to all direct care workers or to family members. The therapist should be very specific about what will be shared and the purpose of this collaboration. There are times when involving staff will be essential and beneficial (e.g., repetition of coping skills between sessions), but the patient must be a part of this decision-making whenever possible.

Involvement of caregivers is essential for several reasons. Individuals with disabilities may be poor historians, and thus unable to provide the necessary details of their current situations or life events. For this reason, it is important to involve caregivers who can provide accurate information regarding how the consumer is doing between appointments and who are also able to assist with the identification of any emergent issues that the clinician may need to address in session.[12] Because the patient will need opportunities to practice the skills learned in therapy, the therapist will also need to depend on involved caregivers to follow up with the patient in between sessions to encourage completion of "homework" or for assistance with practicing learned skills and strategies.[5,6,14]

The therapist's relationship with involved caregivers is vital because of the multidisciplinary team element and acquisition of collateral data are vital components of a course of psychotherapy, as well as medication management by the psychiatrist.

The traditional model of psychotherapy assumes the client has the internal capacity to mentally contain his or her life experiences and then bring them to his or her regularly scheduled appointments.[4] This may not be a good fit for many of individuals with ID who have a limited capacity to do this. Some individuals may struggle with impulse control and live 'in the moment;' in order to provide an effective and meaningful intervention, the clinician must be flexible and address issues as needed versus waiting for the next scheduled weekly appointment.[5] Other patients may have a shortened attention span, and although willing and able to participate in treatment, may be only able to tolerate 20- to 30-minute sessions.[4] The therapist, whenever feasible, should be agreeable to adjusting the intensity and frequency of services provided to match the need of the consumer.

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PSYCHOTHERAPY CASES, CONTINUED

Vanessa. Vanessa was living in a group home and made the decision that she only wanted to befriend the "higher functioning" roommate. This led to ongoing conflict and anger toward the "lower functioning" roommate. Vanessa also expressed sadness secondary to the inability to manage her own money or have things "that other people my age have" (e.g., drive a car, have a husband and children, live in her own apartment without staff).

The therapist spent time with Vanessa, processing her beliefs regarding how society in general thinks of individuals who have disabilities. In the room, they discussed differences between perceived stereotypes and reality, reviewed the importance of accepting ourselves as we are, and helping her to reframe the issues. The therapist focused on what Vanessa could realistically do versus focusing on goals she would not likely attain. Through the psychotherapy, they reviewed and validated situations in which Vanessa was competent and successful.

Rachel. Rachel expressed escalating fear, anger, and sadness related to her terminal medical illness, but was unable to express these feelings directly. Emotional pain manifesting as anger was directed at staff. The therapist worked to help her identify and express her feelings and to become aware of the need to honestly connect to and express them versus misdirecting her grief onto staff. The work in the room focused on identifying and reflecting emotions and gauging Rachel's responsiveness to interventions. Once both Rachel and the therapist determined the need to focus on grief and loss, the therapist made suggestions regarding possible triggers for Rachel's behaviors and provided education regarding normal grief reactions. Much time was spent working through grief issues, and ultimately anger expressions were reduced.

PRACTICE POINT: POWER STRUGGLES WITHIN AND OUTSIDE THE THERAPY RELATIONSHIP

The relationship between staff and a person with a dual diagnosis (intellectual disabilities and mental illness) is as prone to power struggles as in any other type of relationship and, perhaps, even more so.[1,4,10] Training to avoid power struggles should be an integral part of a staff person's preparation.[4,6,10] It is crucial to an understanding of therapeutic alliance and recovery. Patients with ID tend to have very little choice in major areas of their lives.[6] They may have no say in decisions regarding where they live, with whom they live, or where they work. They are not in

charge of their own finances; others are involved with decisions regarding their romantic relationships and recreational activities. Experiences such as these can lead to feelings of powerlessness and an overwhelming desire to establish some form of control in their lives. This may take the form of resistance to rules or oppositional behaviors, and it is essential that staff understand the motivating factors underneath the behaviors and to avoid power struggles whenever possible.

Many individuals with ID struggle with learned helplessness as their life experiences lead them to feel powerless to influence the events that are going on around them.[7] This issue should be addressed in therapy as the patient may not immediately see the value of attempting to make therapeutic change, as the concept of having the ability to create meaningful changes in his or her life seems foreign and at odds with his or her experiences thus far.[5,6] It is important to work to reframe events with an emphasis on the situations in which the patient acts in a competent way and gains a sense of control over his or her own life.

Individuals with ID are often painfully aware of their value in society, and often struggle with the limitations and restrictions in their lives as a result of their disability. They may form a belief system that idolizes being 'normal' and devalues disabilities.[12] This can manifest through the denial of having any disability, attempts to avoid socializing with their peers, or wanting to only form friendships with individuals they see as higher functioning. These issues must be addressed in treatment, with the therapist raising these issues, spending time processing the patient's thoughts and feelings, and supporting a positive self-image.[13] According to Keller, an important tool in this process involves reframing distressing events or behaviors as positive signs of coping.[7]

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Often individuals with ID are discouraged from expressing their emotions, and have been given the message that expression of emotions is inappropriate or indicates a problem. Instead of receiving encouragement to express or discuss their feelings, they are often redirected or told to "walk it off."[15] The role of the therapist is to help the individual begin to experience his or her emotions and learn to interpret his or her feelings as signals of inner life and reactions to the world around him or her. Because involved providers tend to define the expression of emotion as a problem, many patients may need to experience permission to express, or even feel, emotions.[15] The patient needs normalization and validation of his or her feelings and reassurance that it is all right to openly and honestly express him- or herself in appropriate ways.

Given the nature and prevalence of [self-injurious behavior and aggression directed toward others in patients with ID], it is important to not only assess the social variables maintaining the behavior, but it is also essential to screen for medical and psychiatric disorders that may contribute to or exacerbate the problem.

The process of providing psychotherapy to individuals with ID is inherently more complicated than providing the same service to individuals who are not disabled. For persons with disabilities, the process of entering and engaging in psychotherapy is complex and must move more slowly than in traditional treatment methods.[12] Psychotherapy will be more successful if the clinician is able to break down interventions into smaller pieces, allowing room for repetition and practice before moving on to ensure internalization of new information.[14] Because of cognitive limitations, there is a need to modify the approach used to fit each patient's ability to successfully engage in the process of psychotherapy. There are several adaptations clinicians can make that will increase the patient's ability to participate in and benefit from treatment. According to Whitehouse, et al., there is a need to be more directive than in traditional psychotherapy. They note that the use of suggestion, persuasion, and reassurance are useful and will be more effective than non-directive methods.[12] Clinicians should also be flexible and willing to simplify the therapeutic interventions utilized. This can be achieved by reducing the complexity of the techniques used, breaking down interventions into smaller chunks, and shortening the length of sessions. Clinicians also should adapt their language, using shorter sentences and adjusting their vocabulary to match the cognitive abilities of the patient.[12]

CONCLUSIONS

Despite the various problems the patients illustrated in these case vignettes experienced, there were changes that were seen as increased

integration, a better ego-functioning, and decreased use of primitive defenses.

Carlsson, et al., found that for all dual diagnosis patients receiving psychotherapy, handicaps were diminished.[3] For some patients, there were significant changes after about six months of psychotherapy, although many of these changes were subjective. The changes that the members of the project group saw in the patients after 6 to 18 months of psychotherapy were that the patients did not regress so deeply, they had words for traumatic experiences, and they didn't become psychotic as frequently when in crisis. They showed improvement in communication (could pronounce words correctly, had longer sentences, more gestures, reduction of stereotyped monologues, took initiative to communicate). Further changes included increased power of initiative and memory, decrease in stereotypic behavior, decrease of self-destructive behavior, decrease of manic behavior, and increased sadness about the handicap.[3]

The majority of referrals brought to the attention of a clinician consist of complaints regarding self-injurious behavior and aggression directed toward others.[1,2,16] Given the nature and prevalence of these behaviors it is important to not only assess the social variables maintaining the behavior, but it is also essential to screen for medical and psychiatric disorders that may contribute to or exacerbate the problem. This step in assessment helps identify those individuals whose psychopathology is less obvious and less disruptive to the environment of others (e.g., anxiety disorders, depressive disorders), yet problematic for the mental health of the patient. Identification of mental health disorders and variables contributing to behavior problems can be accomplished through the use of indirect assessment, where persons familiar with the patient are questioned regarding observable behavior.[16]

Psychopathology and behavior disorders are of great concern regarding patients with intellectual disabilities. Such conditions impede the person's ability to be integrated successfully into society and may result in job failure and the inability to establish fulfilling social relationships.[2,16] In a substantial group of individuals these problems can be chronic and recalcitrant. Therefore, active attempts to intervene are needed. These interventions require the use of reliable tools, including psychotherapy and all other mental health services available to the general population, to assist the professional.[16]

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